

# I-Decisions Inc.

An Independent Review Organization

5501 A Balcones Drive, #264

Austin, TX 78731

Phone: (512) 394-8504

Fax: (207) 470-1032

Email: manager@i-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/16/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient right side sacroiliac (SI) joint injection times one (1) as related to lumbar

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

M.D. Board Certified Orthopedic Surgeon

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

#### PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work related bilateral sacroiliac strain on xx/xx/xx when she was rear-ended by another car as her car was stopped. An MRI of her hips on 10/12/10 showed symmetrical narrowing. No increased fluid was identified and there was no subchondral cyst formation along the hip joints. The claimant was treated with ultrasound, massage, traction, rehabilitational exercises and chiropractic adjustments. She completed a two-week work-conditioning program. Per Dr.'s office note of 01/31/11, the claimant had a right sacroiliac joint injection on 01/21/11 that gave her 80% pain relief and increased her motion and movement. When she saw Dr. on 04/07/11, the claimant again complained of discomfort in her right sacroiliac joint area that she rated as 6/10. On examination the claimant had tenderness upon palpation in the right sacroiliac joint area, a positive posterior shear test, positive Faber test and positive Fortin finger test. Dr. recommended another right sacroiliac joint injection. This was denied in two peer reviews dated 04/15/11 and 04/22/11 due to the lack of documentation of the duration and effectiveness of the 01/21/11 right sacroiliac joint injection.

#### ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The SI joint injection has not been certified on two prior peer reviews dated 04/15/11 and 04/22/11. For this case, Official Disability Guidelines were used. The diagnosis is that of a history of bilateral SI joint strain due to a work injury xx/xx/xx. The claimant was treated with ultrasound, traction, chiropractic care, and therapy.

She had a right SI joint injection on 01/21/11 that gave 80 percent relief. When seen 04/07/11 she again complained of discomfort in her sacroiliac region. There was tenderness to palpation about the right sacroiliac joint, a positive Faber test, positive Shear test, and positive Fortin finger test. Recommendations were for another right SI joint injection. The previous requests were noncertified due to the fact that there was no duration documented of at least six weeks of improvement following the injection. For this review, there was no documentation concerning the duration of the effectiveness following the injection. The guidelines require the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. This is not documented. Therefore, the reviewer finds no medical necessity for Outpatient right side sacroiliac (SI) joint injection times one (1) as related to lumbar as the ODG Criteria for the

use of sacroiliac blocks has not been satisfied.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011  
Updates. Hip and Pelvis: Sacroiliac blocks

Criteria for the use of sacroiliac blocks

1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above)
2. Diagnostic evaluation must first address any other possible pain generators
3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management
4. Blocks are performed under fluoroscopy. (Hansen, 2003)
5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed
6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period
7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks
8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block
9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE

PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)